

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-036461

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8617 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

<p>FILED SEP 24 1962</p>		<p>1. PLACE OF DEATH # COUNTY</p>		<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY</p>	
<p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u></p>		<p>Length of stay in 1b</p>		<p>c. CITY OR TOWN <u>ST. LOUIS</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/></p>	
<p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>D.O.A. City Hosp. #1</u></p>		<p>Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/></p>		<p>d. STREET ADDRESS (If outside, give location) <u>2610 STODDARD ST</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print) First <u>BESSIE</u> Middle <u>M^CQUIRTER</u> Last</p>			<p>4. DATE OF DEATH Month <u>8</u> Day <u>26</u> Year <u>1962</u></p>		
<p>5. SEX <u>FEMALE</u></p>		<p>6. COLOR OR RACE <u>colored</u></p>		<p>7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/></p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY</p>		<p>9. AGE (last birthday) <u>ABT. 65 yrs</u> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.</p>	
<p>11. BIRTHPLACE (City and state or country) <u>? L.A. U.S.A</u></p>		<p>12. CITIZEN OF WHAT COUNTRY</p>			
<p>13a. FATHER'S NAME <u>UNKNOWN</u></p>		<p>13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u></p>		<p>14. NAME OF HUSBAND OR WIFE <u>?</u></p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u></p>		<p>16. SOCIAL SECURITY NO.</p>		<p>17. INFORMANT Address <u>MARTHA COOPER 2610 STODDARD</u></p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) _____ DUE TO (c) <u>420.1</u></p>					<p>INTERVAL BETWEEN ONSET AND DEATH</p>
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition, given in PART I (a)</p>					<p>PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown</p>
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>		<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>	
<p>20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year</p>		<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>			
<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>20f. CITY, TOWN, OR LOCATION</p>		<p>COUNTY STATE</p>	
<p>21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>5:30 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.</p>					
<p>22a. SIGNATURE (Degree or title) <u>Paul J. Simon Deputy Coroner</u></p>			<p>22b. ADDRESS <u>1300 Clark</u></p>		<p>22c. DATE SIGNED <u>9/7/62</u></p>
<p>23a. BURIAL, CREMATION, REMOVAL (Specify)</p>		<p>23b. DATE <u>9-6-62</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <u>FATHER DICKSON CEM ST. LOUIS, MO</u></p>	
<p>24. FUNERAL DIRECTOR <u>A.F. WALTON 2707 STODDARD ST.</u></p>		<p>25. DATE RECD. BY LOCAL REG. <u>9-6-1962</u></p>		<p>26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u></p>	

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____ Signed _____
Signature of Student Embalmer

not Embalmed
Arthur Walton

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.